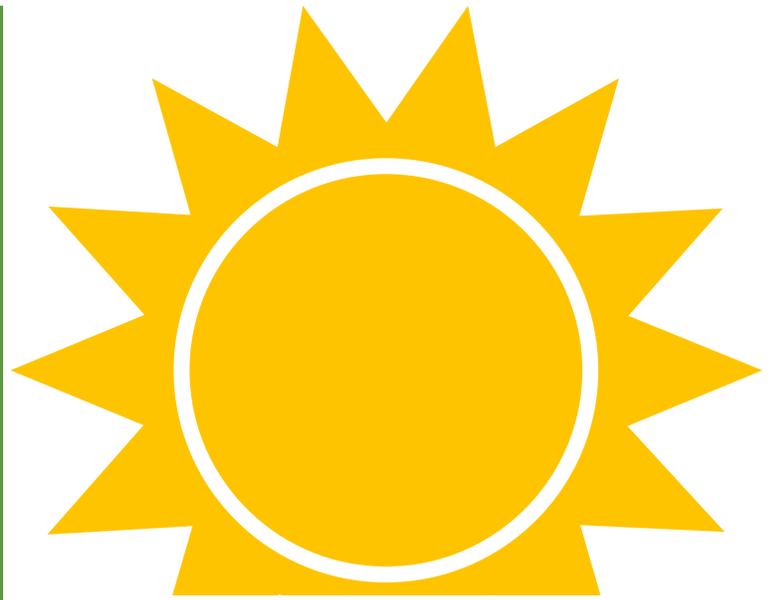


KERSHAW COUNTY
COMMUNITY HEALTH
IMPROVEMENT PLAN

2019-2022



HEALTHIER TOMORROWS
FOR EVERYONE

Introduction & Vision

Kershaw County, South Carolina recognizes the value health plays in the future social and economic well-being of its neighborhoods, towns and communities. Improving the health of the entire county is essential to enhancing one's quality of life. LiveWell Kershaw Coalition is leading an effort to craft a detailed plan to improve the health of all residents living in Kershaw County. A destination postcard is a vivid picture from the near-term future that shows what could be

possible (Heath & Heath, 2011). The cover of this report showcases what the destination postcard looks like for Kershaw County. Our vision is for all residents to be able to access healthcare, achieve optimal emotional health and to be physically active and eat healthy foods. This report outlines the three year plans our residents have co-designed in an effort to achieve our destination postcard of optimal health in Kershaw County.

Overview of the Community Health Improvement Plan

A **Community Health Improvement Plan (CHIP)** is a written plan that outlines key goals and objectives to support the improved health of individual residents in our community. Through a CHIP process, priorities are set, with the primary goal of aligning and coordinating resources to reach identified targets. Our CHIP is a three-year plan (June 1, 2019 - May 31, 2022) that is based on data from the 2017 Community Health Needs Assessment (see page 8 for link to the full report), which included a survey with 1,168 residents, key informant interviews, focus groups and an environmental scan of the entire county. In addition, Youth-Well Being Assessment results from 1,200 high school students were used along with Vision 2030 survey results. Other data sources included: FitnessGram data, Communities That Care data, and snapshot

data sheets provided by the Department of Health and Environmental Control. Key reference documents used included: SC State Health Improvement Plan, the Rural Health Action Plan and the SC Obesity Action Plan.

Ideally, city and county government leaders, non-profits, businesses and residents will be able to clearly see how they fit into the implementation of the CHIP. It is the goal of the LiveWell Kershaw Coalition that organizations will review this three-year plan and determine what specific role they can play in supporting the improvement of health outcomes in our county. This guidance document can be used as policies are being developed and revised and also to determine what key actions and resources are needed to advance the three goals crafted in this plan. This three-year plan can be modified as conditions change.



Health is not the absence of disease but the addition of confidence, skills, knowledge and connection. But most importantly, it is simply a means to an end — which is a joyful, meaningful life.

Cristin Lind

A core set of skills known as the Community of Solutions skills, developed by the 100 Million Healthier Lives Campaign, was used throughout the planning and development of the CHIP (Stout, 2017). LiveWell Kershaw Coalition believes these skills are necessary to lead community transformation work. This framework outlines that communities must **lead from within, lead together, lead for outcomes, lead with equity, and lead for sustainability** in order to achieve a culture of health. Outcomes for a culture of health include, but are not limited to: health as a shared value; thriving cross-sector partnerships; healthy, equitable communities and improved population health; and wellbeing and equity outcomes. As a result of this framework, **the Coalition has adopted a very broad definition of health including “mental, physical, social, [and spiritual] wellbeing”** (adaptation of World Health Organization). Since the adopted definition of health is so broad, all sectors are considered key players in the advancement of improving the health of the county.

The process to develop the CHIP began in February, 2019 and ended in May, 2019. LiveWell Kershaw Coalition intentionally made the planning process as short as possible, in an effort to focus more attention on the implementation plan that follows the CHIP. A kick-off meeting was held on March 27, 2019 with 47 participants representing various sectors and zip codes of the county. At

the kick-off meeting, participants reviewed the 2017 Community Health Needs Assessment and examined the following issues in-depth: access to care, built environment, diabetes, hypertension, mental health, obesity, and substance abuse. Following the data walk and data table discussions, participants voted using PollEverywhere. Criteria for ranking the priorities were based on impact and feasibility to tackle in the next three years. The kick-off meeting ended with three priorities emerging from the original list of seven topics: **access to care (27%), obesity (23%) and mental health (20%)**.

Participants then signed up for workgroups based on the three priorities. During the month of April, the workgroups met three times to develop goal statements, objectives, tactics and outcome metrics. The workgroups ranged from five participants to twelve participants. The mental health workgroup decided to change their name to the emotional health workgroup in an effort to reduce stigma. The draft outline of a plan was then presented on May 3, 2019 with 27 participants, where workgroup members shared their initial thoughts and participants then gave feedback on the initial drafted plan and offered recommendations to strengthen particular elements. Based on the feedback, a complete plan was created and disseminated to members on May 15, 2019. Implementation of the plan will begin by June 1, 2019.

Let him who would be moved to convince others, be first moved to convince himself.

Thomas Carlyle



What Are the Priorities?

What are the Priorities?

1. Access to Care
2. Obesity
3. Emotional Health

*Community members recognize that there is overlap with all three of these issues.

Complete tables for all priorities are found on pages 9-11.



“Being fit and healthy begins in childhood and carries over into adulthood. I started lifting weights at 11 years old, when my mom bought me a pair of 15-pound dumbbells and a jump rope. I was on a mission from then on to get fit for life. My passion is to teach others how to be fit and healthy. If I did it, others can, too!”

**Chris Conde
Lugoff, SC**

What Are Next Steps?

The three priority areas are broad and can feel overwhelming. The goal of this plan is to shrink the change and begin tackling our priorities one piece at a time. This three-year plan will move one step at a time to gain ground before moving to other tasks. We acknowledge that change is difficult. Through strategic action and implementation, we will see indicators of progress as we tackle a strategy at a time. Moving forward, we can expect to follow this outlined process:

1. CHIP report will be disseminated to community organizations and residents
2. Access to Care, Obesity and Emotional Health implementation teams will prioritize action items
3. Teams will finalize their respective metrics and develop a work plan including baseline metrics, strategy leads, and target completion dates for specified activities

Strategic Elements of the CHIP

OBESITY

GOAL Statement

Increase healthy lifestyles among families* countywide in order to decrease the obesity epidemic.

* Families includes ALL adults, children and elderly (everyone).

Outcome Metrics

Obesity rates among adults and children (decrease) & students ranking in top 25% of FitnessGram data for the nation

Objective One

Strengthen existing collaborations.

1. Supporting other groups' current obesity efforts

Objective Two

Implement evidence-based interventions.

1. HEAL (Healthy Eating, Active Living) Champions in schools, faith-based organizations, worksites and local communities
2. School Campaigns (“5-2-1-0” and “Say Yes! to Water)

3. FAN (Faith, Activity and Nutrition) Program for churches
4. Worksite wellness programs
5. Policy changes to decrease obesity
6. Public infrastructure that supports physical activity (outdoor fitness parks, walking trails, community parks)

Objective Three

Conduct an awareness campaign.

1. Mass and small media, social media
2. Local resolutions

Key Partners

American Heart Association, Chamber of Commerce, Dollar General stores, EatSmart MoveMore Kershaw County, elementary schools, grocery stores, SC Hospital Association, LiveWell Kershaw Coalition, local churches, local providers, media outlets, parents, school district, school newspapers/newsletters/broadcast, and Trails Committee

Key Indicators to Watch

Personal stories of transformation, number of local residents participating in local health events and using trails, decrease in screen time, decrease in sugar-sweetened beverages, number of policy changes/types, percentage of participating churches, number of students leading health initiatives, number of participating schools, number of functional trails, number of media presentations/articles

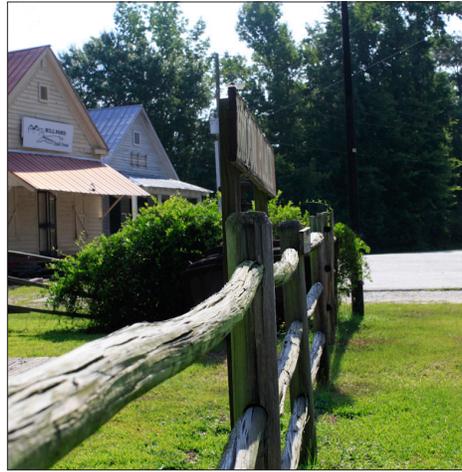
BRIGHT SPOT of a Current Local Effort to Reduce Obesity

Active Living Made Easier with Trails and Complete Streets

With a Healthy South Carolina Initiative grant in 2012, Kershaw County agencies and organizations began to lay the groundwork—literally—to enhance the county’s physical environment to make it easier and safer for residents to be physically active. The Kershaw County Bicycle, Pedestrian and Greenways Plan was developed to set the course for building an on- and off-street bikeway,

walkway, and trails network. It includes “complete streets” designs to promote safer travel for pedestrians, cyclists and drivers, as well as recommended policies and programs to encourage usage of the bikeway, walkway, and trail network, and to promote safe bicycling, walking, and driving practices. County and City councils adopted the plan and incorporated it into their respective comprehensive plans. The greenways plan efforts are ongoing. EatSmart MoveMore Coalition Kershaw County supported and led these efforts. Some of the enhancements to the physical environment thus far include:

- the one-half mile, 10 foot wide, paved Sweet Gum Connector Trail that connects Woodward Park to Scott Park in Camden
- marked and signed pedestrian crosswalks on Broad Street in downtown Camden
- fifty “share the road” signs throughout the county to alert drivers and bicyclists to safely share the roads.





LiveWell
KERSHAW
"Your Bridge to Better Health"

Obesity in Kershaw County



ISSUE

Of the 1,168 Kershaw County residents that completed the survey, 54% identified **OBESITY** as the most important health concern in Kershaw County.

POSSIBLE CAUSES

Some residents believe obesity is linked to:

- Personal choice, lack of motivation to get healthier, laziness, too busy (to focus on health)
- Lack of education on how to be healthy; lack of knowledge of available resources
- Not enough safe, convenient indoor & outdoor places to exercise, especially in rural areas
- Unhealthy food options in grocery stores and restaurants, not enough grocery stores with healthy food options, higher cost of healthy foods, eating too much fast food, not cooking at home
- Not enough primary healthcare providers; lack of affordable healthcare
- “Southern way of living” that is promoted by the county’s culture



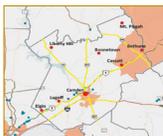

IMPACT

- Kershaw County is the 6th “fattest” county among the 46 counties in South Carolina.
- In 2017, 42.5% of Kershaw County adults 20 years and older considered themselves to be **obese** based on their height and weight.
- **Obesity is rising.** Compared to 2017, in 2013, 31.9% of Kershaw County adults 18 years and older were obese.



Results of the 2017 Kershaw County Community Health Needs Assessment found:

- Kershaw County’s physical environment (roads, sidewalks) is built for automobiles, not pedestrians or bicyclists.
- Kershaw County has “food deserts”— areas (usually low-income) lacking fresh fruit, vegetables and other healthful whole foods due to few or no grocery stores, farmers’ markets and health providers. Food deserts and high obesity rates are linked.



POSSIBLE SOLUTIONS

Residents suggested:

- Access to healthy foods through stores, community gardens, farmer’s market and restaurants
- Meal programs & food vouchers
- Education on healthy living through classes or health fairs
- Gyms, basketball courts and/or indoor walking track areas in the community to encourage a healthy lifestyle
- Community events that emphasize healthy lifestyle competitions

Evidence-based solutions that work in most communities are:

- Active recess time, healthy meals & snacks and obesity prevention programs in schools and childcare & senior centers
- Community exercise/fitness programs, including neighborhood walking groups
- Worksite obesity prevention programs
- “Complete streets” designs (sidewalks, crosswalks, walking paths, bicycle lanes, traffic-calming devices)

Coordinate efforts among the county’s various agencies, organizations, groups and residents.

DATA SOURCES

- 2016-17 Kershaw County Community Health Needs Assessment
- South Carolina County Health Profile (2015-2017) at <http://deh.dhs.sc.gov/ohp>
- 2013 Kershaw County Obesity Risk Survey at http://www.dhs.sc.gov/files/ohp/ohp13/ohp13_HealthNeedsAssessmentKershaw.pdf
- Vision Kershaw 2020 Survey at <http://2020.visionkershaw.com/ohp>
- 2018 State Health Improvement Plan at <https://www.healthysouthcarolina.org/ohp/action-to-improve-health/ohp-action-to-improve-health>
- County Health Rankings & Roadmaps at www.countyhealthrankings.org/ohp/action-to-improve-health/ohp-action-to-improve-health

LiveWell Kershaw Coalition May 2019 Page 4

Goal Statement

Increase and improve ways to access affordable healthcare and transportation services among rural and underserved residents.*

*With dignity and empowerment embedded throughout framework.

Outcome Metrics

Decreased uninsured rate, decrease in avoidable ER visits and readmission rates, and reduction in missed follow-up appointments due to transportation

Objective One

Connect every community member to timely and quality care

1. Workplace wellness (Workplace Health Index, worksite clinic, Doc in a Box, policy change)
2. Telehealth opportunities (existing and new; Alexa homebased solution)
3. Transportation backbone (Rides to Wellness, LYFT, transportation consortium, billboards at bus stops and churches)
4. Mobile clinic (Sullivan Center Model, community paramedicine)

Objective Two

Advocate for meaningful and trusting relationships with community residents.

1. Trainings to Promote Dignity and Empowerment – certification, hot line (incentivize those with lived experience, implicit bias, patient advocates, how to navigate, motivational interviewing)

2. Organizational Policy Revisions (addressing “gatekeepers” and partner engagement)
3. Community Champion Identification (influencers in each community), Identify and address barriers

Key Partners

Census, Chamber of Commerce, community paramedics, Human Affairs Commission, KershawHealth, local churches, local providers, local technical college, network of Human Resource Directors/Committee of 100/Economic Development, patient advocates, “real” communities (race/nationality/geographic location/occupation), school district, school service providers, transportation committee/RTA, and United Way

Key Indicators to Watch

Increase in access to healthcare for those who live west of the river, number of providers accepting Medicare/Medicaid (increase), number of missed follow-up appointments due to transportation (decrease), healthcare visits (NP, PA, Walmart clinic, school



“I moved here from Egypt and was left alone with my kids. I had no one to help me with finding a job, transportation, or medical care. I now have freedom to work, drive my car, and see the doctor because of a navigator.

Access to care is important. Everyone needs help.”

**Elham Hamad
Elgin, SC**

wellness centers, telehealth) in nontraditional locations (increase), HR directors sharing reasons employees missing work, attitudes and perceptions (change over time) related to healthcare (more confidence in availability), number of local policy changes or procedures/type (residency, incentives, time off to see doctors, breaks for telehealth visits)

LiveWell Kershaw
KERSHAW
Your. Our. Together. A World of Possibilities.

ACCESS TO CARE IN KERSHAW COUNTY

Several Kershaw County residents believe that ACCESS TO HEALTH CARE & RESOURCES are root causes to poor health outcomes.

23.4 % of Kershaw County residents are uninsured, compared to 15.1% statewide (2015)

WHAT DOES THE DATA SHOW?
The 2017 Kershaw County Community Health Needs Assessment found:

- Household income varies widely across the county, from near poverty-level to high-income. Poverty is linked to poor health.
- According to healthcare access standards, Kershaw County has enough physical structures to treat patients: hospitals, public health departments, home health agencies, hospices, mental health agencies/clinics, substance abuse centers, assisted living facilities, nursing homes and free clinics/community health centers. BUT...
 - In the past 5 years, the number of primary care physicians in Kershaw County has decreased, and there are not enough OB/GYN doctors or dentists.
 - Almost 1/3 of the county's residents do not have health insurance.
 - Residents are somewhat dissatisfied or disappointed with Kershaw County's ability to meet their healthcare needs.

WHAT ARE SOME CAUSES OF THE PROBLEM?
Some residents believe:

- No health insurance, few affordable health insurance enrollment programs
- Increasing cost of healthcare and overall cost of living
- Lack of public health programs (free preventive health checkups/screenings) and related community resources
- Not enough free clinics
- Few primary care providers and specialists
- Health services that do not fit people's schedules
- Distrust and displeasure with the county's hospital system (low quality scores received)
- Service gaps in available health resources
- Limited or no transportation to medical appointments for residents who live alone, cannot drive or cannot afford it
- Too proud, private or embarrassed to seek help
- Lack of health care/education for people who don't speak English

The 2017 Kershaw County Community Health Needs Assessment found the top 10 reasons for not seeking healthcare are:

1. Cannot pay
2. No insurance
3. Cannot get time off work
4. No family doctor
5. No transportation
6. Inconvenient hours
7. Do not know where to go
8. Not sick
9. No one to keep children
10. Other

WHAT ARE SOME POSSIBLE SOLUTIONS?
Residents suggest:

- Financial help with health insurance and childcare
- Free health screenings provided by medical students
- Transportation services for seniors, rural and limited-income residents for medical appointments
- More free clinics and doctors
- Free housing
- Better-paying jobs

Evidence-based solutions that work in most communities are:

- Community health centers to provide comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay
- Medical care through telehealth technology
- Mobile health units
- Community health workers to help people enroll in health insurance programs, refer patients to care and provide home visits and care coordination
- School dental programs, school-based health centers

Coordinate efforts among the county's various agencies, organizations, groups and residents.

“Without any Medicaid, can't afford to go to the doctor and end up sick and dying with nothing you can do about it.”

DATA SOURCES:
 2016 U.S. Census Bureau Community Health Needs Assessment
 Kaiser Family Foundation 2015 Survey #1
 2016 South Carolina Community Health Needs Assessment
 Kershaw County Health Department & Kershaw County

BRIGHT SPOT of a Current Local Effort to Address Access to Care:

Gatekeepers stand at the entry point of every system, health included. The Community Medical Clinic of Kershaw County identified areas for improvement within their own organization in relation to patients' ability to access health care and feel empowered throughout the process. After undergoing Implicit Bias Training and an Image Shift Workshop, the team agreed to

change organizational policy by providing patients with medical attention prior to undergoing the eligibility process to receive services. Staff members recognized that the in-depth eligibility process can be a barrier to creating trust between medical provider and patient. As a result, the organization has shifted to an intake model that is patient-centered.



EMOTIONAL HEALTH

Goal Statement

Improve the Emotional Well-Being of Kershaw County residents by increasing the quality, availability, and effectiveness of Community Health Programs.

Outcome Metrics

Suicide rate (decrease), drug overdose death rate (decrease), overall well-being (increase)

Objective One

Identify and assess the impact of our local mental health programs and initiatives.

1. Assessment and Evaluation
2. Continuous Quality Improvement

Objective Two

Provide Training and Resources to Prevent Mental Health Crisis.

1. Mental Health First Aid
2. Family Foundations Program
3. GROW model
4. Mindfulness practices
5. Reduce "screen time"

Objective Three

Provide safety-net crisis intervention resources and provide children and youth access to adequate and timely School-Based Behavioral Health Services

1. Community Crisis Response and Intervention
2. Roads of Independence (ROI)
3. Mental Health Counselors at High Schools
4. Creating Lasting Family Connections Programs
5. Health Clubs at High Schools

Key Partners

ALPHA Center, Department of Mental Health, EMS, Family Resource Center, Fire Department, Food for the Soul, Kershaw County Mental Health Task Force, KershawHealth, Law Enforcement, local providers, Mental Health America, Probate Judge, School District/Schools, United Way, and Worksites/employee assistance programs

Key Indicators to Watch

Utilization of the hospital for mental health, When Programs Reach Capacity, Number of Trainings, Support Groups & Manuals Distributed, Inventory Complete of Identification and Assessment of Programs, Impact of interventions (referrals, testimonials)



“Mental health impacts every aspect of a person’s life. I’ve seen how it impacted my family growing up and am now fighting to ensure that my family and children get the support they need to live a full life. We have to start talking about this issue.”
Yolanda Roary
Lugoff, SC

BRIGHT SPOT of a Current Local Initiative to Improve Emotional Health

Mental Health Counselors in High Schools

In the 2018-2019 school year, teachers and administrators referred students to Life Coaches (doctoral students) at North Central High School, North Central Middle School, Camden High School and Lugoff-Elgin High School through a partnership with the University of South Carolina's Community Psychology Program. A total of 81 students were served with most receiving more than five visits and reporting reaching at least half of their goals set by the student and life coach. Students frequently report feeling appreciative that they "have someone to talk to." Students identified problems including feeling overwhelmed, difficulty focusing, feeling sad, trouble sleeping and eating, trouble communicating with others, trouble with family, low grades,



LiveWell
KERSHAW
"Your Bridge to Better Health"

Mental Health in Kershaw County



Kershaw County
All-America City
2018

ISSUE
From key informant interviews, **MENTAL HEALTH ISSUES** were cited as a top health issue that needs more attention in Kershaw County.

WHAT THE DATA SHOWS

- All high school students in Kershaw County completed a well-being survey
 - Among high-schoolers in 2018, females reported lower levels of emotional wellbeing than did males. Only 16.7% of Hispanic students in the North Central community felt they are an important part of their community.
- In 2016, 13% of Kershaw County adults reported 14 or more days per month of poor mental health (depression, stress, emotional problems).
- 38% of residents reported insufficient sleep (less than 7 hours per night) in 2016.
- Kershaw County had the **15th-highest suicide rate among all 46 South Carolina counties in 2017.**

POSSIBLE CAUSES

Some residents say mental health issues result from:

- Lack of social programs and community resources, low enrollment in available programs, lack of knowledge of existing resources
- Lack of affordable health care and/or health insurance
- Few affordable health insurance programs
- Living alone (elderly)
- Too proud, private or embarrassed to seek help, young people think "it won't happen to me"

Results of the 2017 Kershaw County Community Health Needs Assessment found:

- Residents' mental health can be affected by their education level, income level, cost of living, access to affordable and convenient healthcare, health insurance status, community environment and social support system.

POSSIBLE SOLUTIONS

Residents suggest:

- Multimedia marketing about available programs and community resources along with direct marketing to those affected
- Financial help with health insurance
- Social events and activities for seniors, afterschool programs for youth
- Strong faith and fellowship (among people and organizations)
- People and places to make the community feel comfortable and safe when talking about their needs
- Address mental health alongside physical health across the continuum of care, and connect people to resources.
- Better collaboration among social services providers

Evidence-based solutions that work in most communities are:

- Mental Health First Aid training for general public on how to help people with depression, anxiety and substance use disorders
- School-based health centers; community health centers to provide comprehensive care to uninsured and vulnerable patients regardless of ability to pay
- Mentoring programs (e.g., Big Brothers Big Sisters) in schools, churches and community organizations

Coordinate efforts among the county's various agencies, organizations, groups and residents.

"...a lot of our community that needs help don't want to ask for it because they are too proud or stubborn."





DATA SOURCES
 2016-17 Kershaw County Community Health Needs Assessment
 South Carolina County Health Profile (2013-2017) at <http://www.southcarolinahhs.com/>
 Vision Kershaw 2030 Survey at <http://www.visionkershaw.com/>
 2018 State Health Improvement Plan at <http://www.southcarolinahhs.com/state-health-improvement-plan.html>
 2018 State Health Rankings & Roadmaps at www.healthrankings.org/rankings-action-to-improve-health-outcomes-for-health

and academic difficulties. Related goals included decreasing anxiety, being less overwhelmed, gaining self-confidence, not getting stuck on negative thoughts, being assertive, and learning study skills. Funding and support were made possible

by the Community Medical Clinic of Kershaw County, Kershaw County School District and the Health Services District of Kershaw County.

Funding and Project Staff

LiveWell Kershaw Coalition receives funding support through The Duke Endowment as a Healthy People, Healthy Carolinas grantee. Funding for Kershaw County's Community Health Improvement Plan has been provided by the LiveWell Kershaw Coalition and the Health Services District of Kershaw County.



CHIP process and report supported by Iron Sharpens Iron Consulting Group led by Holly Hayes.



Kathryn Johnson, MPH
 Director
 LiveWell Kershaw
 kjohnson@cmcofkc.org
 803.900.1691



Linda Pekuri, MPH, RD, LD
 Health Improvement Facilitator
 LiveWell Kershaw
 lpekuri@cmcofkc.org
 803.900.1767

Participants

Thank you to all our LiveWell Kershaw Coalition members for making our mission possible. LWK Coalition members are individuals of organizations across community sectors willing to give time, energy and effort to the advancement of population health in Kershaw County.

Joey Adams-Raczkowski

Kershaw County

Izabella Baipho

North Central High School

Sheri Baytes

Community Medical Clinic
of Kershaw County

Craig Blankenship

Bethany Baptist Church

David Branham

North Central High School

Susan Burroughs

KershawHealth

Mary Anne Byrd

Kershaw County School District

Laurey Carpenter

SC Thrive

Vic Carpenter

Kershaw County

Susan Collier

Department of Health and
Environmental Control

Chris Conde'

Conde' Wellness

Amber Conger

Kershaw County Library

Michael Conley

Kershaw County

Joanna Craig

Camden City Council

Alfred Mae Drakeford

City of Camden

Felicia Elliott

Concerned Citizen

Phil Elliott

City of Camden

Chrissy Faulkenberry Carraway

Dana Corporation

Laurie Funderburk

SC House of Representatives

Ed Garrison

Concerned Citizen

Bob Giangiorgi

Kershaw County Trails Committee

Larry Gibbes

Concerned Citizen

Bethany Gilliland

Community Medical Clinic
of Kershaw County

Breanna Grant

Department of Health and
Environmental Control

Tina Griggs

The ALPHA Behavioral Center

Elham Hamad

Concerned Citizen

Sallie Harrell

Health Services District of
Kershaw County

Amanda Holland

Concerned Citizen

Annetta Hough

Camden High School

Kathryn Johnson

LiveWell Kershaw Coalition

Crystal Keith

Department of Health and
Environmental Control

Kyle Kelly

Santee-Lynches Regional Council
of Governments

Amy Kinard

Kershaw County Chamber of Commerce

Steve Knafelc

Kershaw County Sheriff's Office

Edwin Kohn

Kershaw County Trails Committee

Carrie Lynch

Concerned Citizen

Darlene Lynch

South Carolina Office of Rural Health

Gina Marthers

First Citizens Bank

Robin McAlpine

Food for the Soul

Laura Mickelson

Concerned Citizen

Rose Montgomery

North Central High School

Linda Pekuri

LiveWell Kershaw Coalition

Margaret Pennebaker

The ALPHA Behavioral Center

Shawn Putnam

City of Camden

Mary Reames

Concerned Citizen

ChandraRichardson

Lugoff-Elgin Middle School

Yolanda Roary

Community Medical Clinic
of Kershaw County

Casey Robinson

Camden Military Academy

Jodi Rogers

Community Medical Clinic
of Kershaw County

James Smith

Kershaw County School Board

Rosalyn Smith-Stover

The Family Resource Center

David Snodgrass

Kershaw County Council

Pam Spivey

EatSmart MoveMore Kershaw County

Maria Spring

Lugoff-Elgin High School

Scott Thorpe

Department of Health and
Environmental Control

Julie Trott

Habitat for Humanity

April Wach

KershawHealth

Liz Walsh

SC Thrive

Tiffany Warren

Sandhills Medical Foundation

Susan Witkowski

Community Medical Clinic
of Kershaw County

References

Heath, Chip, and Dan Heath. Switch: How to Change Things When Change Is Hard. Waterville, Maine: Thorndike Press, 2011.

2017 Community Health Needs Assessment. livewellkershaw.org/2017CHNA

Stout S. Overview of SCALE and a Community of Solutions. SCALE 1.0 Synthesis Reports. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2017.

ACCESS TO CARE

Goal and Outcome Metrics	Objectives	Tactics	Potential Indicators to Watch	Partners
<p>Increase and improve ways to access affordable healthcare and transportation services among rural and underserved residents.* (*With dignity and empowerment embedded throughout framework).</p> <p>Outcome metrics: Decreased uninsured rate, decrease in avoidable ER visits and readmission rates, and reduction in missed follow-up appointments due to transportation</p>	<p>Connect every community member to timely and quality care</p> <p>Advocate for meaningful and trusting relationships with community residents.</p>	<p>Workplace Wellness (Workplace Health Index, Worksite Clinic, Doc in a Box, policy change)</p> <p>Telehealth opportunities (Existing and new; Alexa homebased solution)</p> <p>Transportation Backbone (Rides to Wellness, LVFT, transportation consortium, billboards at bus stops and churches)</p> <p>Mobile Clinic (Sullivan Center Model, Community paramedicine)</p> <p>Trainings to Promote Dignity and Empowerment – certification, hot line (Incentivize those with lived experience, implicit bias, patient advocates, how to navigate, motivational interviewing)</p> <p>Organizational Policy Revisions (Addressing “gatekeepers” and partner engagement)</p> <p>Community Champion Identification (Influencers in each community), Identify and address barriers</p>	<ul style="list-style-type: none"> • Increase in access to healthcare for those who live west of the river • Number of providers accepting Medicare/Medicaid (increase), • Number of Missed follow up appts due to transportation (decrease), • Visits (NP, PA, Walmart clinic, school wellness centers, telehealth) in nontraditional locations (increase), • HR directors sharing reasons employees missing work, healthcare (more confidence in availability), • Attitudes and perceptions (change over time) related to healthcare (more confidence in availability), • Number of local policy changes or procedures/type (residency, incentives, time off to see doctors, breaks for telehealth visits) 	<ul style="list-style-type: none"> • Census • Chamber of Commerce • Community paramedics • Human Affairs Commission • KershawHealth • Local churches • Local providers • Local technical college • Network of Human Resource Directors/ Committee of 100/Economic Development • Patient advocates • “Real” communities (race/nationality/geographic location/occupation) • School district • School service providers • Transportation committee/RTA • United Way

OBESITY

Goal and Outcome Metrics	Objectives	Tactics	Potential Indicators to Watch	Partners
<p>Increase healthy lifestyles among families* countywide in order to decrease the obesity epidemic.</p> <p>*Families include ALL adults, children and elderly (everyone).</p> <p>Outcome metrics: Obesity rates among adults and children (decrease) & students ranking in top 25% of FitnessGram data for the nation</p>	<p>Strengthen existing collaborations</p> <p>Implement evidence-based interventions</p> <p>Conduct an awareness campaign</p>	<p>Supporting other groups' current obesity efforts</p> <p>HEAL (Healthy Eating, Active Living) Champions in schools, faith-based organizations, worksites and local communities</p> <p>School Campaigns ("5-2-1-0" and "Say Yes! to Water)</p> <p>FAN (Faith, Activity and Nutrition) Program for churches</p> <p>Worksite wellness programs</p> <p>Policy changes to decrease obesity</p> <p>Public infrastructure that supports physical activity (outdoor fitness parks, walking trails, community parks)</p> <p>Mass and small media, social media</p> <p>Local resolutions</p>	<ul style="list-style-type: none"> • Personal stories of transformation • Number of local residents participating in local health events and using trails (increase) • Decrease in screen time • Decrease in sugar-sweetened beverages • Number of policy changes/types (increase) • Percentage of participating churches • Number of students leading health initiatives • Number of participating schools • Number of functional trails • Number of media presentations/articles 	<ul style="list-style-type: none"> • American Heart Association • Chamber of Commerce • Dollar Generals • Eat Smart Move More • Kershaw County • Elementary schools • Grocery stores • Hospital Association • LiveWell Kershaw Coalition • Local churches • Local providers • Media outlets • Parents • School district • School Media (newsletters, broadcast) • Trails Committee

EMOTIONAL HEALTH

Goal and Outcome Metrics	Objectives	Tactics	Potential Indicators to Watch	Partners
<p>Improve the Emotional Well-Being of Kershaw County Residents by increasing the quality, availability, and effectiveness of Community Health Programs.</p> <p>Outcome metrics: Suicide rate (decrease), drug overdose death rate (decrease), overall well-being (increase)</p>	<p>Identify and assess the impact of our local mental health programs and initiatives</p> <p>Provide Training and Resources to Prevent Mental Health Crisis.</p>	<p>Assessment and evaluation</p> <p>Continuous Quality Improvement</p> <p>Mental Health First Aid</p> <p>Family Foundations Program</p> <p>GROW Model</p> <p>Mindfulness Practice</p> <p>Strategies to reduce “screen time”</p> <p>Community Crisis Response and Intervention</p> <p>Roads of Independence (ROI)</p> <p>Mental Health Counselors in High Schools</p> <p>Creating Lasting Family Connections Programs</p> <p>Health Clubs at High Schools</p>	<ul style="list-style-type: none"> Utilization of the hospital for mental health When Programs Reach Capacity Utilization of local programs Number of Trainings and support groups Manuals Distributed Inventory Complete of Identification and Assessment of Programs Impact of interventions (referrals, testimonials) 	<ul style="list-style-type: none"> ALPHA Center Department of Mental Health EMS Family Resource Center Fire Department Food for the Soul Kershaw County Mental Health Task Force KershawHealth Law Enforcement Local providers Mental Health America Probate Judge School District/Schools United Way Worksites/employee assistance programs